

2009 AHNS FELLOWSHIP APPLICATION

IDENTIFYING INFORMATION		
Last Name:	First:	Middle:
Home Mailing Address:	City:	
	State:	Zip:
Home Telephone Number:	Email Address:	
Work Mailing Address:	City:	
	State:	Zip:
Work Telephone Number:	Fax Number:	
Birth Date:		
Birth Place (City/State/Country):		
Citizenship:	Visa (if not US citizen):	
Social Security Number:	ECFMG Number:	
Outside Interests & Hobbies:		
PRE-MEDICAL EDUCATION		
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
POSTGRADUATE EDUCATION – PLEASE ENCLOSE A COPY OF YOUR CV		
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:

RESIDENCIES/FELLOWSHIPS			
Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city, zip code, and dates. Include all programs you attended, whether or not completed.			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? ___ Yes ___ No (If "no", please explain)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? ___ Yes ___ No (If "no", please explain)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? ___ Yes ___ No (If "no", please explain)			
PEER REFERENCES			
List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Please obtain original letters of reference from these three individuals and submit them along with your application. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.			
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:

OTHER

Board Certification: Yes No

License Number: State: Exp:

Honors and Awards:

In-training exam score (all years): 1st 2nd 3rd 4th

PROFESSIONAL LIABILITY

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes No

If "yes", please provide list and status on a separate sheet.

Comments: _____

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, placed on probation, not renewed, or voluntarily relinquished? If "yes", please provide full explanation on a separate sheet.

- Medical license in any state Yes No
- Other professional registration/license Yes No
- DEA registration Yes No
- Academic appointment Yes No
- Membership on any hospital medical staff Yes No
- Clinical privileges Yes No
- Prerogative/rights on any medical staff Yes No
- Other institutional affiliation or status threat Yes No
- Professional society membership or fellowship/Board certification Yes No
- Professional office Yes No
- Any other type of professional sanction Yes No
- Professional liability insurance Yes No
- Have there been any felony criminal charges brought against you in the last 5 years. . . Yes No
- Have you been convicted of any crimes Yes No

PERSONAL STATEMENT (Please make this statement about 800 words and do not exceed 1 page)

SIGNATURE:

I hereby certify that, to the best of my knowledge and belief, I have no physical or mental illness or mental defect that interferes with my professional appointment. All information submitted by me in this application is true and accurate to the best of my knowledge and belief.

Signature: _____ Date: _____

Checklist for 2009 Match Applicants

Programs Participating in the 2009 Fellowship Match:

- | | | |
|--|--------------------------------|----------------|
| _____ Johns Hopkins University (1 position) | Application fee: | \$50.00 |
| _____ MD Anderson Cancer Center (3 positions) | | |
| _____ Memorial Sloan-Kettering Cancer Center (3 positions) | # of programs x \$15.00 | _____ |
| _____ Ohio State University (1 position) | | |
| _____ Roswell Park Cancer Institute (1 position) | Total amount enclosed: | _____ |
| _____ Stanford University (1 position) | | |
| _____ University of Alberta (1 position) | | |
| _____ University of California, Davis (1 position) | | |
| _____ University of Cincinnati (1 position) | | |
| _____ University of Iowa (1 position) | | |
| _____ University of Miami (2 positions) | | |
| _____ University of Michigan (2 positions) | | |
| _____ University of Oklahoma (1 position) | | |
| _____ University of Pennsylvania (1 position) | | |
| _____ University of Pittsburgh (3 positions) | | |
| _____ University of South Florida (1 position) | | |
| _____ University of Toronto (3 positions) | | |
| _____ University of Washington (1 position) | | |

Please return this application along with your payment to:

Aaron Goodman
American Head and Neck Society
11300 W. Olympic Blvd. Suite #600
Los Angeles, CA 90064